Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOUGLAS M STAUCH, MD
PO BOX 741865
DALLAS TEXAS 75374

Respondent Name
AMERICAN CASUALTY CO OF READING PA

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-11-1619-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS"

Amount in Dispute: $1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of D60 and attachments, Attorney for the Insurance Company requested that the disputed billing (CPT codes 99456 WP W5 and 99456 Re W8 for Date of Service August 20, 2010) be re-audited for allowable per medical fee guidelines. Carrier will forward the Explanation of Review on receipt and payment will be promptly issued in the recommended allowable amount."

Response Submitted by: Law Offices of Brian J. Judis, 600 N. Pearl, Suite 1450, Dallas, Texas 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2010	99456 WP-W5 and 99456-RE-W8	$1,150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services.
3. No EOBs were received by Requestor prior to submission to Medical Fee Dispute Resolution.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated February 10, 2011

- W1 – Workers Compensation State Fee Schedule Adjustment
- (855-002) – RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS COMPENSATION MEDICAL FEE SCHEDULE GUIDELINES. $350.00.
- (900-031) – PROVIDER DOES NOT PARTICIPATE IN THE TX WC HCN.

Issues

1. Has the Designated Doctor Examination (DDE) been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed the amount of $650.00 for CPT code 99456-WP-W5 for Maximum Medical Improvement/Impairment Rating (MMI/IR) as a Designated Doctor (DD). The provider also billed $500.00 for CPT Code 99456-RE-W8 for a Return to Work (RTW) evaluation. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(D)(v), the MAR for an IR using non-musculoskeletal DRE method is $150.00. Per Texas Administrative Code §134.204(k), the MAR for RTW is $500.00.
2. Review of the documentation supports that MMI was assigned and one body area was rated. A non-musculoskeletal condition DRE method IR was used for partial medial meniscectomy. The documentation also supports that a RTW evaluation was performed.
3. The combined MAR for the MMI/IR services rendered is $1,000.00. According to the carrier response and confirmation with the provider, the Respondent paid $350.00 for the MMI/IR determination and $500.00 for the RTW evaluation after filing MFDR. The Requestor is due a recommended reimbursement of $150.00.

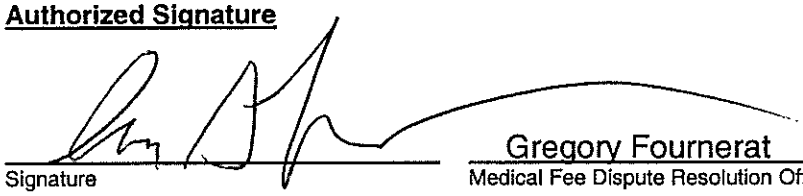
Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature



Signature

Gregory Fournerat
Medical Fee Dispute Resolution Officer

October 11, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.